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Indian Health Service
Rockville MD 20857

Dear Tribal Leader:

I am providing you my decision on the diabetes funding for fiscal year (FY) 2002 and a description of the funding methodology. The Balanced Budget Act of 1997 (BBA) provides \$30 million annually for the Special Diabetes Program for Indians through FY 2002. The Consolidated Appropriations Act of 2001 (H.R. 4577) authorizes an additional \$70 million in FYs 2001 and 2002 and \$100 million in FY 2003. This year's funding marks the fourth year of a 5-year congressional appropriation supporting the tribal and Federal leadership concerns about the impact of diabetes on American Indian and Alaska Native people. It is critical for the Indian Health Service (IHS), tribes, and urban Indian programs to demonstrate successes that will make a difference in the lives of American Indian and Alaska Native people and their communities.

I have decided to allocate the FY 2002 diabetes funding totaling \$93 million (after set-asides for the urban diabetes grant programs, data improvement, and administrative and program support costs) to the IHS Areas. In FY 2002, the \$93 million will be allocated using a modification of the original 1997 BBA diabetes funding allocation methodology: 57.5 percent disease burden (defined as 75 percent prevalence and 25 percent mortality), 30, percent user count, and 12.5 percent tribal size adjustment. The Resources and Patient Management System data from 1998 will be used to calculate diabetes prevalence. I believe that my decisions for distributing the FY 2002 funds provide a fair distribution of funds and the least disruption of programs currently operating in tribal communities. These decisions apply for FY 2002 only.

I have directed each IHS Area to conduct tribal consultation to decide specific amounts for each FY 2002 diabetes grantee. I assure you that we will again consult with tribes about how these funds will be distributed in FY 2003, when we expect new prevalence data to be available for use in next year's formula.

I collaborated with the Tribal Leaders Diabetes Committee (TLDC) in authorizing Area tribal consultations this past year to

provide information to tribal and community health leaders on the new funding. Our intent was to obtain input for the TLDC's final recommendations on the distribution of the new funding.

Tribal leaders expressed different opinions about the FY 2002 funding cycle data issues during the Area consultations and in correspondence to me. Some tribal leaders asked that the FY 2001 formula be retained, specifically supporting the inclusion of both prevalence of diabetes and diabetes mortality as equal measures (50 percent each) of disease burden. Other tribal leaders cited several studies that have shown diabetes mortality data to be inaccurate and an under-representation of true mortality due to diabetes and, therefore, advocated for using diabetes prevalence as the full measure (100 percent) of disease burden. Others suggested that aspects of the formula relating to tribal size and/or rate of the rise of diabetes prevalence should be removed or added.

In making my decision for FY 2002, I carefully reviewed the following:

- The effect of the outcomes of each of the above variations in the formula on Area programs.
- The TLDC's recommendation that the FY 2001 formula be retained for FY 2002.
- The TLDC co-chairs concurrence on the use of 57.5 percent disease burden (75 percent prevalence and 25 percent mortality).

I have decided that the set-asides from FY 2001 will remain unchanged. The Urban Indian Health Programs (UIHP) will be funded at \$5 million, the same level as in FY 2001 (\$1.5 million from BBA funds and \$3.5 million from H.R. 4577 funds). The UIHP have received grants on a national basis under the Title V authorities of the Indian Health Care Improvement Act. The amount provided gives the urban programs the opportunity to continue to expand and enhance their existing diabetes programs.

Administrative funding and program support costs will remain the same as FY 2001 (\$300,000 from BBA funds and \$3.5 million H.R. 4577 funds), which is well below the 10 percent upper limit suggested for these activities. These funds are to be used to provide support for 1) data improvement and grants management

activities at both the national and Area levels, 2) programmatic support for the National Diabetes Program including data improvement, 3) grants program evaluation (as required by the Congress) and technical assistance, 4) support for Area diabetes programmatic activities, and 5) support for TLDC activities.

I want to thank the members of the TLDC and all the tribal leaders and Indian health program representatives who participated in the regional and national consultation activities held this year. Once again, the TLDC compiled the consultation issues from each Area, summarized and discussed your major concerns, and formulated their national recommendations that were presented to me for a final decision. Their efforts are reflective of the great concern that tribal leaders have for the epidemic of diabetes that plagues Indian country and their willingness to devote time to addressing it.

I believe that the collaborations that we have established and decisions that we have made together will help Indian people live a healthier life in healthier communities.

Sincerely yours,

/Michael W. Trujillo/

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Enclosure